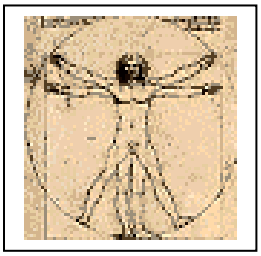

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Assessment and Treatment of Individuals with Mental Illness and a Co-Occurring Substance Abuse Disorder

The purpose of this guide is to provide case managers and physicians with information to facilitate treatment of individuals with serious and persistent mental illness who also have a co-occurring substance abuse disorder.

Introduction: The term substance abuse describes either abuse or dependence on alcohol, marijuana, cocaine or opiates based on DSM IV criteria. Research suggests that approximately 50 percent of individuals with mental illness have an active substance abuse disorder, and rates are as high as 70 percent in some inner city community settings. Compared to the general population, individuals with mental illness are three times more likely to have an alcohol use disorder and more than six times more likely to have a drug use disorder. Drug use in consumers with mental illness is associated with:

1) symptom exacerbations and higher use of hospitalization (recidivism)
2) greater risk for HIV and other medical problems
3) greater risk for hepatitis infection
4) homelessness
5) suicidality
6) poor adherence

Substance abuse creates a barrier to treatment that is often devastating to the individual with the disorder, troubling for the family members, and a burden on the system and providers who care for them. Recognition and management of substance abuse problems in mental illness spectrum disorders can have an important impact on outcomes.

Point to Case Manager 1: ***Poorer outcomes occur when antipsychotic medications are discontinued by substance abusing consumers.***

It is common for substance abuse to be under-identified or under-reported at the time of hospitalization in consumers with mental illness. The treatment team may assume a consumer is not responding to treatment and either increase or change medications to no avail. Urine toxicology screenings can be helpful at admission and provide an objective finding to be discussed between the clinician and the consumer.

Point to Case Manager 2: ***Exacerbation of psychosis is often incorrectly attributed to other factors when substance abuse goes unrecognized.***

Assessment of Consumers with Dual Diagnosis: Accurate assessment of the severity of the substance abuse in individuals with mental illness spectrum disorders is challenging. These individuals are often poor historians and rarely present with an individual who can provide collateral information. Furthermore, substance abuse can cause a wide range of psychotic symptoms that may occur during acute intoxication, withdrawal, or chronic use. Individuals with psychotic disorders experience psychiatric symptoms following smaller and briefer exposures to drugs of abuse than other substance abusers. Typical symptoms and the substances most often associated with them are discussed below.

Point to Case Manager 3: ***Drugs of abuse can cause a variety of psychotic symptoms that can overlap core symptoms of mental illness.***

Delusions: Paranoid or grandiose delusions are often associated with psychostimulant abuse including amphetamines and cocaine. They typically occur after an escalating period of use (speed run) and are more likely to emerge when the route of administration is by smoking (inhalation) or injection. Once drug induced delusions have occurred, even small quantities and brief exposure are frequently sufficient to precipitate a recurrence. Treatment is usually supportive but the mentally ill consumer may require hospitalization or increased dose of antipsychotic medication.

Paranoia: Paranoia often accompanies repeated and chronic marijuana use. A significant proportion of individuals with mental illness regularly use marijuana, and it may contribute to a perception of partial response or residual symptoms. Psychostimulants (as noted above) are also associated with paranoid states.

Hallucinations: Visual hallucinations may occur as part of alcohol withdrawal. This medically serious and potentially life threatening condition known as delirium tremens (DTs), may be accompanied by changes in consciousness, disorientation, agitation and seizures. Delirium tremens constitutes a true medical emergency, and individuals in whom this is suspected should be referred for immediate medical evaluation. Flashbacks, i.e. vivid visual re-experiencing of actual events may occur days or years following hallucinogen use. Auditory hallucinations are less frequent but may occur as part of a stimulant induced psychosis.

Anxiety: Anxiety accompanies a wide range of intoxications and withdrawal syndromes. It is common during withdrawal from alcohol and sedative-hypnotics. Such withdrawal may be inadvertent or iatrogenic, as when consumers are admitted to a hospital and their use of alcohol or benzodiazepines is unknown or undocumented. Seizures may be a significant risk in these individuals. Anxiety, agitation, diaphoresis and abdominal cramping occur during opiate withdrawal. Stimulants, marijuana and hallucinogens can all cause significant anxiety in susceptible individuals.

Insomnia: Insomnia is most often seen during acute intoxication with stimulants, hallucinogens and PCP. Withdrawal from opiates, alcohol and sedative/hypnotic drugs can also cause insomnia.

Point to Case Manager 4: ***When substance abuse is suspected, it is important to gather all available information including hospital records, collateral interviews and repeated clinical interviews.***

A review of hospital records and collateral information can reduce the problems of poor memory, confusion and inconsistent reporting. Similarly, a more complete and forthright history may be obtained when the interview is repeated after acute phase symptoms have resolved and the consumer is more stable. The elements of a substance abuse history should include:

1) the amount and frequency of each drug used
2) the amount spent for each drug on a recurring basis (per day, per week)
3) information on periods of abstinence
4) triggers and cues for drug use
5) severity of drug cravings
6) presence of cognitive impairments
7) medical problems related to substance abuse
8) family history of psychiatric and substance use disorders
9) history of suicide attempts or hospitalizations for suicidal ideation
10) history of past treatments and outcomes, their previous use of 12-Step programs such as AA and Dual Diagnosis Anonymous, and the relationships they have had with sponsors

A cognitive assessment should include orientation, attention, and memory tasks. A variety of more sophisticated instruments exists to evaluate cognition if impairment is identified.

It is recommended that craving be evaluated by direct inquiry or by using a scale that is specific for the individual's drug of choice. Cocaine is particularly problematic since individuals with mental illness have higher craving early in recovery, which may explain high relapse rates common among this population. In fact, studies suggest that individuals with mental illness and cocaine dependence have a great deal of craving and at high intensity, which persists for at least several weeks after the onset of recovery. Clinicians should regularly discuss cravings and urges with their clients and familiarize themselves with techniques that help to manage the craving state.

<u>Point to Case Manager 5</u>: Suicide is a major cause of death in individuals with co-morbidities. Suicidal risk should be carefully evaluated and documented at every appointment in mental illness consumers with current or past history of substance abuse.

A past history or presence of substance or alcohol abuse markedly increases the risk of a suicidal event. In one study, individuals with co-occurring disorders were at 60 percent greater risk of suicide attempts and completions than those without substance abuse. Substance abuse was the single greatest predictor for suicidal behavior.

Approaches to Treatment

<u>Medications:</u>
Medications used in the dually diagnosed population must be chosen carefully. Certain medication classes that have known addictive properties should be avoided whenever possible since they could exacerbate an existing substance abuse problem.

<u>Point to Case Manager 6</u>: Poorer outcomes occur when consumers with co-morbidities are treated with benzodiazepines other than for acute detoxification. Sedative hypnotic medications should similarly be avoided.

The use of benzodiazepines in this population should be avoided since they are abusable, sedating, and can produce memory problems or amnesia. The sedating/amnesic effects can be synergistic with drugs and alcohol. If benzodiazepines cannot be avoided, there are ways to minimize abuse potential. Those with a slower onset of action and longer half-life, such as chlordiazepoxide (Librium) or clonazapam (Klonopin), will have less potential for abuse. The extended-release formulation of alprazolam (Xanax XR) is preferable to immediate-release alprazolam in terms of abuse potential.

Medications without abuse potential are always preferred for the treatment of anxiety, depressive disorders, and sleep problems among individuals with a co-morbid substance abuse disorder. Non-benzodiazepines including SSRIs and buspirone (Buspar) would appear to offer both efficacy and safety to this group. Buspirone does not produce additive sedation or psychomotor impairment when combined with alcohol & drugs. Sertraline (Zoloft) and fluoxetine (Prozac) have been safely used in numerous controlled clinical trials in alcohol, opioid, cannabis and cocaine users. Fluvoxamine (Luvox) should be avoided in methadone maintenance consumers because it can raise methadone levels and increase overdose risk.

<u>Point to Case Manager 7</u>: Nearly all data suggest that atypical antipsychotics are more effective than typical antipsychotic agents in this group.

There is a growing body of literature to suggest that atypical antipsychotics have advantages over typical neuroleptics because the latter is associated with fewer side effects and a lower incidence of EPS. Furthermore, atypical antipsychotics appear to have anticraving effects for cocaine, alcohol and even nicotine. Studies comparing atypicals to typicals have found better outcomes with olanzapine and clozapine in consumers with co-occurring mental illness and addiction. While the literature does not support a preferred atypical agent, there is sufficient research to suggest the use of an atypical over a typical agent.

<u>Treatment Programs</u>

The most effective treatment programs for dually diagnosed consumers with mental illness are integrated, provide psychosocial treatments, and employ case management.

Integrated Treatments

Effective dual diagnosis programs combine or integrate mental health and substance abuse interventions that are tailored for the complex needs of this population. *Integrated interventions* are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions. The main advantage of integrated treatment programs for this population is that they have specialized services to treat the addiction related problems along with the fluctuations in positive and negative symptoms of mental illness, cognitive limitations, lack of social support, suicidal ideation. Integrated interventions can include a wide range of techniques. There are also 12-step therapy groups for individuals with a mental illness and substance abuse disorder (example: Double Trouble Groups). These are similar to AA/NA, but include attention to mental health issues important in recovery. Some examples of integrated treatments include:

- Integrated screening and assessment processes
- Double Trouble mutual self-help meetings
- Dual recovery groups (in which recovery skills for both disorders are discussed)
- Motivational enhancement interventions (individual or group) that address issues related to both mental health and substance abuse or dependence problems
- Group interventions for persons with a mental disorder, and a substance use disorder
- Combined psychopharmacological interventions, in which an individual receives medication designed to reduce cravings for substances as well as medication for a mental disorder.

Point to Case Manager 8: ***Psychosocial substance abuse treatment programs designed for individuals with mental illness spectrum disorders markedly improve outcome. Abstinence oriented support groups can also be helpful as adjunctive treatment or when a dedicated program is not available.***

Psychosocial Treatments: It is particularly important to provide comprehensive psychosocial approaches to assist with treatment engagement and to foster community integration. These approaches often blend traditional addiction treatments (relapse prevention, motivational enhancement therapy (MET), and 12-step facilitation) with mental health approaches (cognitive-behavioral therapy and social skills training). As previously mentioned, many of these approaches incorporate motivational enhancement therapy as the foundation to assist with the initial treatment engagement that is often difficult for this population. The approaches listed above only differ in terms of their emphasis on a particular theoretical orientation or approach, and all focus on managing the addictive disorder simultaneously. However, because of the high attrition rate common among this population, particularly early in recovery, assertive outreach is also necessary.

Point to Case Manager 9: Individuals with comorbidity are especially vulnerable to unstable housing or homelessness. Geographic continuity is essential to successful intervention and requires close coordination between clinic, hospital and social services.

Case Management**:** Treatment attrition is striking among individuals with mental illness who abuse substances. Studies have reported treatment completion rates that range from 15 percent to 33 percent. High dropout rates are also common prior to treatment initiation, with a recent study showing a preadmission attrition rate of 36 percent.

Case management is an important strategy to address this problem and to bridge gaps in fragmented healthcare systems. Assertive Community Treatment (ACT) is a comprehensive intervention that combines features of earlier models with the direct and on-going provision of services using a multi-disciplinary team approach. ACT services include community outreach, 24-hour support, and help with symptom management. *A low client-to-staff ratio has been identified as one of the most critical components of the model*. Short term case management models are also being developed to reduce the often overburdened ACT programs and provide time-limited transitional support while individuals are transitioned from the hospital to the community. Case management treatments must always involve co-occurring substance abuse and mental health treatment either embedded in the case management program or as an add on service. The majority of the existing dually diagnosed

services offer motivational enhancement, relapse prevention, psychoeducational skills training to assist and referrals to 12-step therapy.